U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 March 2006

Case No: 2004-BLA-5813

In the Matter of
CAROLYN ANN ROSS,
Claimant,

v.

GOLDEN OAK MINING COMPANY, L.P.,
Employer,
and
AMERICAN MINING INSURANCE,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
James D. Holiday, Esquire
For the Claimant

David H. Neeley, Esquire
For the Employer/Carrier

Donna E. Sonnor
For the Director, OWCP

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. § 901-962, (hereinafter referred to as "the Act") and the regulations

thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that title.[1]

On February 18, 2004, this case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs. (DX 44)[2] A formal hearing on this matter was conducted on May 24, 2005 in Hazard, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call witnesses, to examine and cross-examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether this claim was timely filed;

2. The length of Claimant's coal mine employment;

3. Whether she has pneumoconiosis as defined by the Act and regulations;

4. Whether her pneumoconiosis arose out of coal mine employment;

5. Whether she is totally disabled; and

6. Whether her disability is due to pneumoconiosis;

(DX 44[3]).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed.Reg. 80,045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2] In this decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to Claimant's Exhibits and "Tr." Refers to the official transcript of the proceeding.

[3] The issues of whether Ms. Ross was a miner within the meaning of the Act, dependency, survivor, Responsible Operator, subsequent claims, modification and fault were initially listed as contested issues, but were withdrawn by counsel for the employer at the hearing. The employer also lists issues under 18(b) on form CM-1025 which are beyond the authority of the Administrative Law Judge, but are preserved for appeal purposes.

Background

Claimant, Carolyn Ross, was born in 1948 and obtained her GED. (DX 2). She was married, but divorced in 1983. Also, Claimant's previous husband is deceased. She has two children who are both over the age of eighteen. Therefore, I find that Claimant has no dependents for purpose of augmentation.

Claimant estimated that she had a total of about fifteen years of coal mine employment, from 1977 to 1995, and that she was laid off for periods of this time. (Tr. 13-15; DX 2). All of her coal mine work was underground. Ms. Ross testified that she began working in the coal mines in 1977 at Scotia, where she did general inside work, such as shoveled coal, built brattice, worked on the belt lines, and anything else that needed to be done. She worked for several coal mines and her last work was for Golden Oak. Her last job with Golden Oak was as a general inside worker and she performed duties that involved lifting six foot timbers, brattice box rock dust, and she often carried two fifty pound bags of rock dust at a time, one under each arm. (Tr. 16). Her employment ended in 1995. Claimant stated that she was fired at that time because she was unable to do the work. She stated that she had carpel tunnel surgery and when she returned to work, asked for an outside job because shoveling coal was difficult, but management wouldn't let her. (Tr. 10-11). Ms. Ross stated that she was usually the only woman working at Golden Oak, although she knew women who worked in other mines. She testified that women had to "give their all" in the mines because women needed to "make the grade" and that some men felt women were bad luck in the mines. (Tr. 18-23).

Ms. Ross testified that Dr. Breeding is her family physician, and Dr. Alam is her treating physician for breathing problems. (Tr. 12, 19). She indicated that she was first hospitalized for breathing problems in 2001. (Tr. 19). Claimant stated that she began smoking cigarettes at around the age of sixteen or seventeen at the rate of around one and one-half pack per day. She estimated that although it sometimes varied, she smoked about two packs per day in her 30's until around 2002 when she had a heart attack and she cut down to one pack per day. At the hearing, she stated that she is now down to six cigarettes per day and is still trying to taper off. (Tr. 19-28).

Procedural History

Ms. Ross filed her claim for benefits on October 31, 2002. (DX 2). The District Director denied the claim on October 28, 2003. (DX 41). Claimant requested a formal hearing and the claim was transferred to the Office of Administrative Law Judges on February 18, 2004. (DX 42, 44).

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is

actually diagnosed by a doctor, regardless of whether the miner believes she has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

Claimant stated that she had breathing problems and her mom kept taking her to the hospital until she saw Dr. Alam in 2001, who told her she had black lung and should file a claim. She stated that she waited a year and when her breathing really started to bother her, she filed this claim for black lung benefits. She stated that prior to 2001 she had not seen a doctor for treatment of her lung problems. (Tr. 12, 30-31). As no evidence has been presented to rebut the presumption that this claim was timely, I find that the claim was timely filed.

Length of Coal Mine Employment

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to ascertain the beginning and ending dates of coal mine employment by using any credible evidence. There are several permissible sources of credible evidence. First, an administrative law judge may rely solely upon a coal mine employment history form completed by the miner. *See Harkey v. Alabama-By-Products Corp.*, 7 B.L.R. 1-26 (1984). A miner's uncontradicted and credible testimony may also be the exclusive basis for a finding on the length of miner's coal mine employment. See *Bizarri v. Consolidation Coal Co*., 7 B.L.R. 1-343 (1984); *Coval v. Pike Coal Co*., 7 B.L.R. 1-272 (1984). If the miner's testimony is unreliable, it is permissible for an administrative law judge to credit Social Security records over the miner's testimony. See *Tackett v. Director*, OWCP, 6 B.L.R. 1-839 (1984).

In her application for benefits, Ms. Ross alleged fifteen years of coal mine employment. The record contains Claimant's reported coal mine history, Social Security records, and Claimant's testimony at the hearing. (DX 3, 4, 7). The Social Security Earnings report reflects the following coal mine employment earnings history:

Year	Earnings	Industry Average for 125 days of CM	Years of Coal Mine Employment
1977	$16,500.00	$ 8987.50	1.00
1978	$ 8,087.00	$10,038.75	.81
1979	$ 7,423.43	$10,878.75	.68
1981	$21,180.63	$12,100.00	1.00
1982	$21,211.87	$12698.75	1.00
1983	$ 4,293.00	$13,720.00	.31
1984	$ 8,692.30	$14,800.00	.59
1985	$12,022.94	$15,250.00	.79
1986	$20,042.12	$15,390.00	1.00
1987	$23,878.27	$15,750.00	1.00
1988	$24,557.53	$15,940.00	1.00
1989	$13,558.34	$16,250.00	.83
1990	$27,625.24	$16,710.00	1.00
1991	$25,129.70	$17,080.00	1.00

1992	$26,025.18	$17,200.00	1.00
1993	$25,066.71	$17,260.00	1.00
1994	$25,128.71	$17,760.00	1.00
1995	$15,661.17	$18,440.00	.85
		Total:	15.86

Therefore, based on the Social Security Earnings Record and Claimant's reported length of coal mine employment, I find that Ms. Ross has established 15.86 years of qualifying coal mine employment.

Claimant's last coal mine employment was in the Commonwealth of Kentucky, therefore, the law of the Sixth Circuit is controlling.

Medical Evidence

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or paragraph § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under §725.414. § 725.406(b).

The District Director completed a Black Lung Benefits Act Evidence Summary Form. DX 47. The Director designated Dr. Hussain's January 8, 2003 examination, x-ray, and arterial blood gas study and his April 2, 2003 pulmonary function study. (DX 12). No other evidence has been designated. As this evidence meets the criteria for submission of evidence, it is hereby admitted.

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 5). As initial evidence, Claimant designated the February 17, 2003 and November 8, 2003 x-ray readings of Dr. Baker (CX 3, 4), the March 26, 2003 and May 30, 2002 pulmonary function studies of Dr. Alam (DX), the November 18, 2002 arterial blood gas study of Dr. Alam (DX),

and the medical reports of Drs. Alam (DX 27) and Baker (CX 1). Claimant has also submitted a report of a lung biopsy by Dr. Shiu-Kee Chan (DX 21) and various medical records. (DX 31, 32). As this evidence meets the criteria for submission of medical evidence, it is hereby admitted.

The Employer also completed a Black Lung Benefits Act Evidence Summary Form. (EX 3). Employer designated the February 17, 2003 x-ray, pulmonary function study, arterial blood gas study and medical report of Dr. Dahhan (DX 20), along with the consultative medical report and deposition of Dr. Westerfield (EX 1) as affirmative evidence. Employer also submitted Dr. Halbert's re-reading of the January 8, 2003 x-ray as rebuttal evidence. (DX 22). As this evidence meets the criteria for eligibility it is hereby admitted.

The employer has also submitted a medical report of Dr. Caffrey as rebuttal evidence. (EX 2). However, Dr. Caffrey's report contains not only a review of the biopsy slides, but also includes a complete review of the medical records and consultative report of the other medical evidence in this claim. As the employer has already designated the reports of Drs. Dahhan and Westerfield as affirmative evidence, Dr. Caffrey's report would constitute the third medical report and would be inadmissible as exceeding the evidentiary limitations. Recently, the Board found it was within an administrative law judge's discretion to sever parts of an exhibit which contained both admissible and non-admissible medical evidence. *Webber v. Peabody Coal Co.,* 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006)*; see also Tapley v. Bethenergy Mines, Inc.,* BRB No. 04-0790 (May 26, 2005)(Unpub.)(the Board affirmed the administrative law judges consideration of the physician's review of biopsy tissue as a "biopsy report," and exclusion of the physician's review of the remaining evidence because it would have constituted a third medical report and thus exceed the limitations of §725.414(a)(3)(i)). Therefore, I find that the portion of Dr. Caffrey's report which discusses his review of the biopsy slides is admissible as rebuttal evidence to Dr. Chan's report. However, the remainder of the report exceeds the limitations on medical evidence and will not be considered.

X-Ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 12	1-08-03	1-08-03	Hussain	2/1
DX 13	1-08-03	2-08-03	Barret, BCR, B	Quality 1
CX 4	1-08-03	4-25-05	Baker, B	1/0
DX 22	1-08-03	5-05-03	Halbert, BCR, B	No pneumoconiosis
DX 20	2-17-03	2-17-03	Dahhan, B	0/0
CX 3	2-17-03	4-25-05	Baker, B	1/0

Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height[4]	FEV_1	FVC	MVV	FEV_1/ FVC	Comments/ Qualifying
DX 31	Alam	54	1.30	1.75	-	74%	No.
5-20-02		62"					
DX 20	Dahhan	55	1.15	1.57	31	73%	Yes
2-17-03		62"	1.19	1.56	27	76%	Yes
DX 31	Alam	55	1.21	1.75	-	70%	Yes
3-26-03		62"					
DX 12	Hussain	55	1.08	1.53	44	71%	Yes
4-2-03		63"	1.03	1.43	-	72%	Yes

Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Qualifying
DX 31	10-18-00	Alam	47.7	76.2	No
DX 12	01-08-03	Hussain	44.8	64	Yes
			41.6	66	Yes
DX 20	02-17-03	Dahhan	49.5	56.5	Yes

Narrative Medical Evidence

Dr. Imtiaz Hussain performed an examination of Ms. Ross on January 8, 2003. Dr. Hussain noted that Claimant had 15 years of coal mine employment, all underground. He also noted that she began smoking around the age of 18 and was currently smoking at the rate of eight cigarettes per day. The physician indicated that Claimant reported sputum production, wheezing, dyspnea and cough and that she had been hospitalized for pneumonia in 2002 and had stents put in her heart. Dr. Hussain performed an x-ray, which he noted was positive for pneumoconiosis, a pulmonary function study which showed poor effort, and an arterial blood gas study which showed hypoxemia. The pulmonary function study was repeated on April 2, 2003 and the results were determined acceptable by Dr. Burki. Dr. Hussain diagnosed pneumoconiosis based on dust exposure and coronary artery disease due to atherosclerosis. He determined that Claimant has a severe impairment which is 100% attributable to pneumoconiosis. (DX 12).

Dr. A. Dahhan examined Claimant on February 17, 2003 and prepared a report of his findings. Dr. Dahhan indicated that Claimant worked for 15 years in coal mine employment, ending in 1995 because of arthritis and carpal tunnel syndrome. The physician noted that the

[4] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP,* 9 B.L.R. 1-221 (1983). Therefore, I find the miner's actual height is 62 inches.

coal mine work was all underground and involved jobs such as a roof bolter and shuttle car operator. Dr. Dahhan indicated that Claimant quit smoking a week before the examination, but prior to that, smoked two packs a day, beginning at the age of 17 for a total of around 60+ pack years. The physician noted a history of daily cough with little sputum, an occasional wheeze, and that Claimant was using Proventil 4 times a day and oxygen as needed. Claimant reported having dyspnea on exertion, such as walking a few feet. She also reported occasional chest pain, and a history of coronary artery disease with a heart attack requiring stent placement in January 2001. Dr. Dahhan performed an examination of the chest, noting an increased AP diameter with reduced air entry to both lungs, along with bilateral and scattered expiratory wheeze and prolongation of expiratory phase. He performed an arterial blood gas study, a pulmonary function study and a carboxyhemoglobin study which indicated an individual smoking over two packs per day. He also performed an x-ray which showed cardiac enlargement with hyperventilation, consistent with emphysema, but was read as negative for pneumoconiosis. Dr. Dahhan also reviewed information submitted with Ms. Ross' claim for benefits, including her description of her coal mine employment and the physical requirements. Based on his examination, Dr. Dahhan concluded that there are insufficient findings to justify diagnosing coal workers' pneumoconiosis. He stated that there was an obstructive abnormality on clinical examination and pulmonary function study and a negative x-ray. Dr. Dahhan diagnosed chronic bronchitis and emphysema. He also determined that Claimant does not retain the pulmonary capacity to continue coal mine employment or similar work. He determined that the pulmonary impairment was the result of a lengthy smoking history and that based on the markedly elevated carboxyhemoglobin levels, Claimant continues to smoke. The physician concluded that the pulmonary disease was not caused, related to or contributed to by the inhalation of coal dust. He also noted that Claimant ceased coal mine work in 1995, and this time period is sufficient to cause cessation of any industrial bronchitis she may have had. He indicated that the obstructive ventilatory defect is severe and disabling in nature, a finding rarely, if ever, seen secondary to pure inhalation of coal dust. He further noted that there was not any evidence of complicated pneumoconiosis or progressive massive fibrosis to cause a secondary obstructive abnormality. Dr. Dahhan is Board certified in Internal and Pulmonary medicine. (DX 20).

Dr. Mahmood Alam completed a "Treating Physician Questionnaire" on August 11, 2003, in which he indicated that Claimant has an occupational disease caused by coal mine employment, based on her history of coal mine employment, pulmonary function studies, x-rays and lung biopsies. He stated that she has clinical, not legal pneumoconiosis and the disease has significantly contributed to her "moderate impairment." He stated that the pulmonary impairment was due to both coal dust and tobacco abuse and that Claimant does not have the respiratory capacity to perform coal mine employment. Dr. Alam indicated that he has been treating Ms. Ross for approximately 1 ½ years. Dr. Alam is Board Certified in Internal medicine, critical care and pulmonary medicine. (DX 27).

Dr. B.T. Westerfield performed a review of the medical records and reports of Drs. Dahhan, Hussain and Alam, along with the x-ray interpretations of Dr. Halbert, and the pathology report. Dr. Westerfield noted that the description of anthracotic pigmentation on a pathology report in Claimant's medical records is not a diagnosis of coal workers' pneumoconiosis. He explained that the diagnosis of coal workers' pneumoconiosis requires coal macules and the microscopic description of anthracosis is the deposition of carbon in lung tissue

and is a common finding, most frequently in smokers. On this basis, he found Dr. Alam's interpretation of the pathology report erroneous. Dr. Westerfield noted that the medical records do not establish a diagnosis of coal workers' pneumoconiosis, but do show severe chronic obstructive pulmonary disease, which is totally disabling. He determined that the etiology of the disease is cigarette smoke, as Claimant has a very strong habit and continues to smoke. Dr. Westerfield is Board Certified in Internal and Pulmonary medicine. (DX 29).

Dr. Westerfield discussed his review of the medical records in detail at a deposition. He disagreed with Dr. Alam's diagnosis of pneumoconiosis, and stated that although Dr. Alam found that the lung biopsy showed "anthrasilicotic pigment compatible with coal workers' pneumoconiosis" the actual pathology report did not make such a finding. He stated that "anthracosis" as found on the biopsy is not a medical diagnosis of pneumoconiosis, but simply means the presence of carbon material in the lung tissue. He stated that anthracosis is present in any cigarette smoker or person inhaling the products of combustion and that everyone has some anthracosis, either more or less depending on the cleanliness of the surrounding environment. He also disagreed with Dr. Alam's statement that Claimant had "minimal tobacco use." Dr. Westerfield explained that his determination that there is no evidence of coal workers' pneumoconiosis was based primarily on the biopsy as this method is the "ultimate in assessing lung disease." He explained that the diagnostic criteria for pneumoconiosis on biopsy, a coal macule or nodule, surrounded by macrophanges and scar tissue, and often focal emphysema, was not found. Dr. Westerfield stated that Claimant does have chronic obstructive pulmonary disease which is due to smoking. He further explained that his determination that smoking and not coal mine dust inhalation was the cause of Claimant's lung disease was that the type of lung dysfunction, airway obstruction with hypoxemia and increased carbon monoxide on blood cells, was completely consistent with the type of disorder caused by smoking and there is no evidence of any disease or condition caused or contributed to by coal mine employment. Dr. Westerfield testified that it is possible to have pneumoconiosis in the absence of positive x-rays, but there is nothing in the medical records to suggest a diagnosis of coal workers' pneumoconiosis. (EX 1).

Dr. Glen Baker reviewed Claimant's medical records from her treating physicians, Drs. Alam and Breeding. He notes that the physicians have concluded that she has coal workers' pneumoconiosis, chronic obstructive airway disease essential hypertension and degenerative joint disease and is on multiple medications for the conditions. Dr. Baker noted that Claimant had a lung biopsy that showed anthracotic pigment but no coal macules. He notes that whether or not the coal macules were present is unclear, but it would be difficult to diagnose through a biopsy obtained through bronchoscopy. Dr. Baker stated that the records indicate Claimant had a CT scan that showed bibasilar fibrotic changes which would be consistent with coal workers' pneumoconiosis. Dr. Baker also indicated that he read two of Claimant's x-rays, taken on January 18, 2003 and February 17, 2003. He noted that the underlying breast shadows cause some difficulty in interpreting for pneumoconiosis, but it was his opinion that the x-rays are positive for pneumoconiosis. He stated that his determination of pneumoconiosis is based on 15 to 18 years of coal dust exposure and x-ray changes, along with the presence of CT findings of pulmonary fibrosis. Dr. Baker also indicated that he had reviewed the reports of Drs. Dahhan and Westerfield. He stated that there is no way to partition the effects of coal dust and cigarette smoking on the lungs, and that coal dust can cause obstructive airway disease. Dr. Baker cites studies from NIOSH that conclude one-half to one year of coal dust exposure equals one pack-

year of smoking and stated that on this basis, there is some contribution from her 15 years of coal mine employment, although it is a small degree, perhaps 15 to 20%. He stated that he was unsure if this percentage was a "significant contribution." He stated that the predominate symptoms are probably caused by her cigarette smoking and there may be a synergistic or additive effect from the coal dust exposure and cigarette smoking that would worsen her condition if she had not had one exposure or the other. Dr. Baker concluded that Claimant has severe obstructive airway disease and lacks the pulmonary capacity to perform the work of a coal miner or similar work in a dust-free environment. (CX 1). Dr. Baker is Board Certified in Internal and Pulmonary medicine. (CX 2).

Biopsy Reports

A pathology report written by Dr. Shiu-Kee Chan documents the findings of a biopsy/bronchial washings on September 25, 2002. The report lists diagnoses of pulmonary fibrosis and chronic obstructive pulmonary disease. The description states that there are fragments of bronchial mucosa and alveolar tissue with mild deposition of anthracotic pigment. (DX 22).

Dr. Raphael Caffrey performed a review of the biopsy slides. He noted that in a large piece of lung tissue, there is a mild amount of anthracotic pigment. Dr. Caffrey stated that he did not find the lesion of coal workers' pneumoconiosis, namely anthracotic pigment with the production of reticulum and associated focal emphysema present in the tissue. He further noted that no nodules were present. Dr. Caffrey diagnosed: 1) mild amount of anthracotic pigment present; 2) no evidence of coal workers' pneumoconiosis; and 3) no evidence of malignancy or any other specific lung disease. Dr. Caffrey is Board Certified in Anatomical and Clinical Pathology. (EX 2).

Medical Records

Claimant's records from Mountain Comprehensive Health Care were submitted as evidence in this claim. The records include various examination and testing reports from Drs. Alam and Breeding. The most recent records note that Claimant has a history of coal workers' pneumoconiosis and a prior history or heavy tobacco use. A March 4, 2003 examination report from Dr. Breeding diagnoses chronic obstructive pulmonary disease with pulmonary fibrosis and indicates that Claimant continues to smoke 6 cigarettes per day. A report from Dr. Alam on November 18, 2002, indicates that Claimant underwent a bronchoscopy and the results showed anthrasilicotic pigment. It also states that Claimant underwent a high resolution CT scan in early 2000 that showed basilar fibrosis and her FEV1 was 55% of predicted, all of which points to a reasonable medical opinion that it is most likely from her underlying coal workers' pneumoconiosis. He states that although the patient has a history of tobacco abuse, she says she has cut down to 8 cigarettes per day and that there is a component of COPD from tobacco use, but it cannot all be blamed on tobacco and has to have some component from black lung. Other diagnoses in the records include arthritis, back pain, carpal tunnel, CAD, hypertension, osteoarthritis and obesity. The records also document various medications Claimant was prescribed. (DX 31).

A respiratory equipment maintenance form from Dr. Breeding was also submitted as evidence in this claim. This form indicates that Claimant is using home oxygen. (DX 32).

Dr. Mahmood Alam's March 26, 2003 examination report stated that the patient is well-known to him and has a history of COPD with coal workers' pneumoconiosis. He noted that she had a CT scan of the chest in late 2000 which showed basilar pulmonary fibrosis and PFTs that were compatible with severe airflow obstruction. He noted that Claimant underwent a bronchoscopy with biopsies which showed deposition of anthrasilocotic pigment compatible with coal workers' pneumoconiosis and with her history. Dr. Alam noted that Claimant is now only smoking six cigarettes per day and has cough and sputum production, and is using Pulmicort and updraft therapy. He stated that she worked 15 years in coal mine employment and was exposed to a lot of dust and although she is a smoker, the pulmonary function studies and biopsies are compatible with coal workers' pneumoconiosis. His diagnoses included coal workers' pneumoconiosis, shortness of breath, and minimal tobacco abuse. (DX 21).

Smoking History

Claimant testified that she smoked cigarettes at a rate of 1 ½ packs per day from age 16 until approximately age 30, two packs per day from age 30 until age 54, and one pack per day from age 54 until age 57. (Tr. 19-28). She added that she currently only smokes six cigarettes per day, but is attempting to quit. Claimant's testimony adds up to a total of 72 pack-years. Dr. Hussain reported that Claimant smoked from age 18 until age 55, but currently smokes only eight cigarettes per day. (DX 12). Dr. Dahhan reported a smoking history from age 17 until 55 at a rate of two packs per day. (DX 20). While Dr. Dahhan noted a 60 pack year total, the years and rate he reported equates to 74 pack-years. In addition, Dr. Dahhan noted that Claimant alleged that she quit smoking the week before the examination, but that his carboxyhemoglobin study revealed that she continued to smoke at a rate of two packs per day. Dr. Westerfield reported a very strong, continuous smoking habit. Dr. Baker reported a 50 to 60 pack year continuing smoking habit. (CX 2). Dr. Breeding reported a smoking habit of six cigarettes per day. (DX 31) Dr. Alam reported an eight cigarette per day continuing habit. (DX 21, 31).

I presume that the Claimant would not purposely overstate her smoking history, thereby presenting a possible detriment to her own case. As a result, I find Claimant's testimony to be the most persuasive. Therefore, I find that while Claimant has a 72 pack-year smoking history, she currently only smokes at a rate of six cigarettes per day.

II. Discussion

Because Ms. Ross filed her application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that she has pneumoconiosis, that her pneumoconiosis arose from coal mine employment, that she is totally disabled, and that her total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

The Act defines "pneumoconiosis" as "a chronic dust disease of the lung and its sequellae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. The record contains five interpretations of two chest x-rays. Of these interpretations, two were negative for pneumoconiosis while three were positive. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 BLR 1-6 (1988); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc).

The first x-ray in this claim was read positive by Dr. Hussain, who does not have any special qualifications for reading x-rays and by Dr. Baker who is a B-reader. This film was also read as negative by Dr. Halbert, who is qualified as both a B-reader and Board certified radiologist. Because of his superior radiological qualifications, I give greater weight to the interpretation of Dr. Halbert and find this x-ray is negative for pneumoconiosis.

The second x-ray was read as positive by Dr. Baker. Dr. Dahhan, a B-reader, interpreted the film as negative. As both readers of this film are equally qualified, I find that the readings in equipoise and find that it fails to establish the existence of pneumoconiosis by a preponderance of the evidence.

Because the negative reading of the first film was performed by the most highly-qualified physician, and the second film does not establish pneumoconiosis, I find that the x-ray evidence is negative for pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. A diagnosis of anthracosis can be the equivalent of a diagnosis of pneumoconiosis. *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536 (11th Cir. 1993). An Administrative Law Judge must also consider biopsy evidence which indicates the presence of anthracotic pigment. *Lykins v. Director, OWCP,* 819 F.2d 146 (6th Cir. 1987). A finding of black pigmentation alone is insufficient to support a diagnosis of coal workers' pneumoconiosis. *Griffith v. Director, OWCP,* 49 F.3d 184 (6th Cir. 1995).

The pathology report submitted in this case does not establish pneumoconiosis. Although Dr. Shiu-Kee Chan noted anthracotic pigment, as mentioned above, this finding alone is insufficient to diagnose pneumoconiosis. In addition, Dr. Caffrey reviewed the biopsy slides and found only a mild amount of anthracotic pigmentation. He specifically discussed the required findings to diagnose pneumoconiosis on biopsy and how they were not present in his review of Claimant's biopsy slides. Therefore, I find that Claimant has failed to establish the existence of pneumoconiosis by biopsy evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no

such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under this section, a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 BLR 1-22, 1-24 (1986).

Dr. Hussain determined that Claimant has pneumoconiosis based on an x-ray and coal dust exposure. However, I give less weight to his opinion on this issue. The x-ray Dr. Hussain determined was positive was re-read by a dually qualified physician as negative and I have determined the x-ray evidence as a whole does not support a finding of pneumoconiosis. Moreover, an opinion which relies solely on an x-ray and coal dust exposure without explaining how the duration of a miner's coal mine employment supports a diagnosis of the presence or absence of pneumoconiosis renders the opinion, "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc*., 8 BLR 1-405 (1985); *see also Worhach v. Director, OWCP*, 17 BLR 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.,* 12 BLR 1-111, 1-113 (1989)). Moreover, Dr. Hussain fails to discuss any effect Claimant's extensive smoking history may have had on her lung condition. As his opinion does not discuss all forms of causation, I find it of little probative weight. *See Cannelton Industries Inc., v. Director, OWCP [Frye]* Case No. 03-1232 (4th Cir. April 5, 2004) (unpub).

Dr. Alam is Claimant's treating physician and also rendered an opinion that she suffers from pneumoconiosis. Although Dr. Alam was the miner's treating physician, his report must still meet standards for reliability. While a treating physician may have the benefit of observing the miner over time and may be more familiar with the miner's condition, his status as a treating physician does not require that his opinion be given greater weight. See *Consolidation Coal Co. v. Director, OWCP*, 314 F.3d 184 (4th Cir. 2002). This is particularly true when the report is not well-reasoned or well-documented. An administrative law judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

Several factors must be considered in determining whether a treating physician's report is entitled to special weight. 20 C.F.R. § 718.104(d)(2001). First, the nature, frequency and duration of the relationship must be examined. In this case, the record indicates that Claimant has been seeing Dr. Alam since 2001, which at the time of Dr. Alam's report, he indicated was approximately one and a half years. The extent of the physician's treatment must also be examined. Based on the medical records and Claimant's testimony, it appears that she has seen Dr. Alam several times since he began treating her, and that some pulmonary function studies and a lung biopsy were performed as part of her treatment. The reasoning and documentation of

the report must also be reviewed. A treating physician's opinion must be well-reasoned and well-documented in the same manner as any other opinion of record. "A simple principle is evident: in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). I find Dr. Alam's report is not persuasive for several reasons. First, Dr. Alam states that Claimant has pneumoconiosis based on coal mine employment, pulmonary function studies x-rays and lung biopsies. As previously mentioned, I have determined that the x-ray evidence does not support a finding of pneumoconiosis. Moreover, Dr. Alam mischaracterizes the lung biopsy as showing "anthrasilicotic pigment compatible with coal workers' pneumoconiosis," but the pathologist did not make such a finding. As discussed above, a finding of anthracotic pigment alone does not support a diagnosis of pneumoconiosis. Accordingly, I give less weight to Dr. Alam's opinion.

Dr. Baker also diagnosed pneumoconiosis after reviewing Claimant's medical records. His diagnosis was based on 15 to 18 years of coal dust exposure, x-rays he read as positive for the disease, and CT scan findings of pulmonary fibrosis. However, as discussed, the x-ray evidence does not support a finding of pneumoconiosis. In addition, neither the actual CT scans, nor the reports of the CT scans that Dr. Baker refers to are not in the record. Instead, the references are from reports of Dr. Alam, in which he mentions that Claimant had CT scans in "early 2000." Accordingly, I find Dr. Baker's report is insufficiently documented, and thus, entitled to less weight on this issue.

Dr. Dahhan determined that there are insufficient findings to justify a diagnosis of pneumoconiosis. His report is thorough, and is well-documented and well-reasoned. He discusses the various physical findings that would indicate Claimant's coal mine employment played a role in her lung disease, and how each finding is not present on examination or testing. Accordingly, I give probative weight to his report on this issue. Dr. Westerfield also determined that Claimant does not have pneumoconiosis. In the same manner, Dr. Westerfield discussed the medical evidence and how each examination or test result was insufficient to support a diagnosis of the disease. Both physicians' reports are well-documented and well-reasoned and are better supported by the medical data in the record. *Minnich v. Pagnotti Enterprises, Inc*. 9 BLR 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985).

After considering all of the medical reports, I find that the reports of Drs. Dahhan and Westerfield outweigh the contrary reports of Drs. Hussain, Alam and Baker. Accordingly, I find the medical reports do not establish the existence of pneumoconiosis.

Claimant has failed to prove by a preponderance of the evidence that she suffers from pneumoconiosis under subsection (a)(1)-(4). Therefore, upon consideration of all evidence under §718.202(a), I find that Claimant has failed to prove the existence of pneumoconiosis.

Total Disability

As the evidence does not establish the existence of pneumoconiosis, this claim cannot succeed. Although, as discussed below, Claimant has established total disability, the disability must be due to pneumoconiosis for benefits to be awarded.

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(2). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(c) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(c)(1) and (c)(2), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies.[5] The three most recent pulmonary function studies and the two most recent arterial blood gas studies meet the requirements for establishing total disability.

Section 718.204(c)(3) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (c)(1), (c)(2), or (c)(3), § 718.204(c)(4) provides another means to prove total disability. Under this section, total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work. All of the physicians of record agree that Claimant is totally disabled and is unable to perform her previous coal mine employment from a respiratory standpoint. Therefore, I find that she is totally disabled.

However, claimant must also establish that her total disability is due to pneumoconiosis. 20 C.F.R. § 718.204(b). To satisfy this requirement, the United States Court of Appeals for the Sixth Circuit requires a claimant to prove that her totally disabling respiratory is due "at least in part" to his pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d, 818, 825 (6th Cir. 1989). This means the miner "must affirmatively establish that pneumoconiosis is a contributing cause of some discernable consequence to his totally disabling respiratory impairment. The miner's pneumoconiosis must be more than merely a speculative cause of his disability." *Peabody Coal Co. v. Smith,* 127 F.3d 504, 507 (6th Cir. 1997). As I have found that the record does not support a finding of pneumoconiosis, Claimant cannot establish that her total disability is due to the disease.

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[5] A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(c)(1) and (c)(2). A "non-qualifying" test produces results that exceed the table values.

In conclusion, although the evidence establishes that Claimant is totally disabled from a respiratory standpoint, it does not establish that she has pneumoconiosis or that pneumoconiosis is the cause of her total disability.

Entitlement

As the Claimant, Carolyn Ross, has failed to prove, by a preponderance of the evidence that she has pneumoconiosis or that her total disability is due to the disease, I find that she is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of CAROLYN ROSS for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Alan Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).